EEOC Form 5 (5/01)

CHARGE OF DISCRIMINATION

This form is affected by the Privacy Act of 1974. See enclosed Privacy Act Statement and other information before completing this form.

Charge Presented To: ☐ FEPA ☒ EEOC

Agency(ies) Charge No(s): 440-2007-03487

Illinois Department Of Human Rights and EEOC
State or local Agency, if any

Name (indicate Mr., Ms., Mrs.)	Home Phone (Incl. Area Code)	Date of Birth
Mrs. Deborah J. Gaspari	(708) 371-0690	07-07-1951

Street Address: 15143 Harding, Midlothian, IL 60445

Named is the Employer, Labor Organization, Employment Agency, Apprenticeship Committee, or State or Local Government Agency That I Believe Discriminated Against Me or Others. (If more than two, list under PARTICULARS below.)

Name	No. Employees, Members	Phone No. (Include Area Code)
ADVOCATE CHRIST MEDICAL CENTER	500 or More	(708) 684-8000

Street Address: 4440 West 95th Street, Oak Lawn, IL 60453

Name	No. Employees, Members	Phone No. (Include Area Code)

Street Address: City, State and ZIP Code:

DISCRIMINATION BASED ON (Check appropriate box(es).)

☐ RACE ☐ COLOR ☐ SEX ☐ RELIGION ☐ NATIONAL ORIGIN
☐ RETALIATION ☐ AGE ☒ DISABILITY ☐ OTHER (Specify below.)

DATE(S) DISCRIMINATION TOOK PLACE
Earliest: 02-16-2007 Latest: 03-02-2007

☐ CONTINUING ACTION

THE PARTICULARS ARE (If additional paper is needed, attach extra sheet(s)):

I began employment with Respondent in August 1991. My last position was Licensed Practical Nurse. On or about February 15, 2007 I was placed on a Performance Deficiency Plan for a 90-day period. On or about March 2, 2007 I was constructive discharged from employment.

I believe I have been discriminated against because of disability in violation of the Americans with Disabilities Act of 1990.

RECEIVED EEOC
MAR 07 2007
CHICAGO DISTRICT OFC

I want this charge filed with both the EEOC and the State or local Agency, if any. I will advise the agencies if I change my address or phone number and I will cooperate fully with them in the processing of my charge in accordance with their procedures.

I declare under penalty of perjury that the above is true and correct.

Mar 02, 2007
Date

Charging Party Signature

NOTARY – When necessary for State and Local Agency Requirements

I swear or affirm that I have read the above charge and that it is true to the best of my knowledge, information and belief.
SIGNATURE OF COMPLAINANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS DATE
(month, day, year)

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
Chicago District Office
500 West Madison St., Suite 2800
Chicago, IL 60661
PH: (312) 353-2713
TDD: (312) 353-2421
MEDIATION FAX: (312) 353-6676

RECEIVED EEOC

MAR 02 2007

CHICAGO DISTRICT OFFICE

Acceptance/Objection to Mediation

1. This Acceptance/Objection is submitted to Mary B. Manzo, ADR Coordinator, Equal Employment Opportunity Commission, with respect to the referral to mediation of:

EEOC Charge Number 440-2007-03187

Charging Party DEBORAH J. GASPARI

Respondent ADVOCATE CHRIST MEDICAL CENTER

2. The undersigned is (check one):
____ (a) the Charging Party
____ (b) an officer/official of the Respondent
____ (c) attorney of record in this matter for ____ (a), ____ (b).

3. I/my client have/has reviewed the materials provided by the EEOC describing its mediation services, and are fully informed regarding the benefits and responsibilities involved in use of those services.

4. Upon due consideration, I/my client have/has determined to (check one):

____ Accept referral of the above-referenced Charge to mediation. It is understood that you will be contacted by the mediator assigned to this Charge in the near future to arrange for a mediation conference date.

____ Object to referral of the above-referenced Charge to mediation. It is understood that rejection of EEOC mediation services is a waiver of the opportunity to use these services, which will result in the referral of this Charge to investigation upon receipt of this submission.

X Undecided at this time and requesting contact by the Mediation Unit to discuss.

3/2/07
Date

Signature of Party/Attorney

Name: Deborah Gaspari Phone: (708) 371-0690

Address: 15145 HARLEM Fax:

Email:

MIDLOTHIAN, IL 60445

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
Chicago District Office

500 West Madison Street, Suite 2800
Chicago, IL 60661
(312) 353-2713
TTY (312) 353-2421
FAX (312) 353-4041

Please immediately complete the entire form and return it to the U.S. Equal Employment Opportunity Commission ("EEOC") at the address above. REMEMBER, a charge of employment discrimination must be filed within the time limits imposed by law, generally within 180 days or in some places 300 days of the alleged discrimination. Upon receipt, this form will be reviewed to determine EEOC coverage. Answer all questions as completely as possible, and attach additional pages if needed to complete your response(s). Incomplete responses may delay further processing of your questionnaire by EEOC. If you do not know the answer to a question, answer by stating "not known." If a question is not applicable, write "n/a."

(PLEASE PRINT)
1. Personal Information

Last Name: Gaspari, First Name: Deborah, MI: J.
Street or Mailing Address: 15143 HARDING, Apt. Or Unit #:
City: Midlothian, County: Cook, State: IL, Zip: 60445
Phone Numbers: Home: (708) 371-0690, Work: ( )
Cell: (708) 837-6263, Email Address: gaspari@aol.com
Date of Birth: 7/7/51, Sex: Male ___ Female ✓, Race: White
National Origin / Ethnicity: ___, Do You Have a Disability? Yes No

Provide The Name Of A Person We Can Contact If We Are Unable To Reach You:

Name: Angelo Gaspari, Relationship: husband
Address: 15143 HARDING
City: Midlothian, State: IL, Zip: 60445, Home Phone: (708) 371-0690
Other Phone: (708) 837-6263

I believe that I was discriminated against by the following organization(s): (Check those that apply)

Employer ✓ Union ___ Employment Agency ___ Other (Please Specify) ___

2. Organization Contact Information

Organization #1 Name: Advocate Christ Medical Center / Advocate Health Care Oak Brook
Address: 4440 W 95th St
City: Oak Lawn, State: IL, Zip: 60453, Phone: (708) 684-8000
Type of Business: Healthcare, Job Location if different from Org.: Oak Lawn
Address: Same as above
City: ___ State: ___ Zip: ___ Phone: ( )
Human Resources Director or Owner
Name: Robin Fell, Phone: (708) 684-8000

Number of Employees in the Organization at All Locations: Please Check (✓) One

Less Than 15 _____ 15 – 100 _____ 101 – 200 _____ 201 – 500 _____ More than 500 ___✓___

Organization #2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #(___) _____

Type of Business: _____ Job Location if not at Org. _____

Address: _____ City: _____ State: _____ Zip: _____

Human Resources Director or Owner Name: _____ Phone: (___) _____

Number Of Employees In The Organization At All Locations: please check (✓) one

Less Than 15 _____ 15 – 100 _____ 101 – 200 _____ 201 – 500 _____ More 500 _____

3. Your Employment Data (Complete as many items as you can)

Date Hired: 8/91 Job Title At Hire: LPN

Pay Rate When Hired: $15.00 Last or Current Pay Rate: $38.50

Job Title at Time of Alleged Discrimination: Manager of Cl. Operations

Name and Title of Immediate Supervisor: Melinda Noonan

IF Applicant, Date You Applied for Job: _____ Job Title Applied For: _____

4. What is the reason (basis) for your claim of employment discrimination?

FOR EXAMPLE, if you are over the age of 40 and feel you were treated worse than younger employees or you have other evidence of discrimination, you should check (✓) AGE. If you feel that you were treated worse than those not of your race or you have other evidence of discrimination, you should check (✓) RACE. If you feel the adverse treatment was due to multiple reasons, such as your sex, religion and national origin, you should check all three. If you complained about discrimination, participated in someone else' s complaint or if you filed a charge of discrimination and a negative action was threatened or taken, you should check (✓) RETALIATION

Race ___ Sex ___ Age ___ Disability ✓ National Origin ___ Color ___ Religion ___ Retaliation ✓

Pregnancy ___ Other reason (basis) for discrimination (Explain) _____

5. What happened to you that you believe was discriminatory? Include the date(s) of harm, action(s) and include the name(s) and title(s) of the persons who you believe discriminated against you. (Example: 10/02/06 – Written Warning from Supervisor, Mr. John Soto)

A) Date: Feb. 07 Action: Performance Deficiency

Name and Title of Person(s) Responsible: Melinda Noonan

B) Date: _____ Action: _____

Name and Title of Person(s) Responsible _____

Describe any other actions you believe were discriminatory. FMLA
I am on intermittent
Staff have complained about being short staffed D/T called
…ing Staffing

(Attach additional pages if needed to complete your response.)

6. What reason(s) were given to you for the acts you consider discriminatory? By whom? Title?
Retaliation, able to speak for others

7. Name and describe others who were in the same situation as you. Explain any similar or different treatment. Who was treated worse, who was treated better, and who was treated the same? Provide race, sex, age, national origin, religion, and/or disability status of comparator if known and if connected with your claim of discrimination. Add additional sheets if needed.

Full Name Job Title Description

1. Elizabeth McDowell (Afro American) Age
2. ________
3. ________

Answer questions 8-10 only if you are claiming discrimination based on disability. If not, skip to question 11.

8. Please check (✓) all that apply:
✓ Yes, I have an actual disability
___ I have had an actual disability in the past
___ No disability but the organization treats me as if I am disabled

9. If you are alleging discrimination because of your disability, what is the name of your disability? How does your disability affect your daily life or work activities, e.g., what does your disability prevent or limit you from doing, if anything? (Example: lifting, sleeping normally, breathing normally, pulling, walking, climbing, caring for yourself, working, etc.).
Nerve impingement / difficulty walking – sitting – stand – sleeping

10. Did you ask your employer for any assistance or change in working condition because of your disability?

YES ✓ NO ___

Did you need this assistance or change in working condition in order to do your job?

YES ✓ NO ___

If "YES", when? Work @ home To whom did you make the request? Provide full name of person Melinda Norman How did you ask (verbally or in writing)? Verbally

Describe the assistance or change in working condition requested?

Have tried to work off days / time

11. Are there any witnesses to the alleged discriminatory incidents? If yes, please identify them below and indicate what they will say. Add additional pages if necessary.

NAME JOB TITLE ADDRESS & PHONE NUMBER

A.

NAME JOB TITLE ADDRESS & PHONE NUMBER

B.

NAME JOB TITLE ADDRESS & PHONE NUMBER

C.

12. Have you filed a charge previously in this matter with EEOC or another agency? YES ____ NO ✓

13. If you have filed a complaint with another agency, provide name of agency and date of filing:

No

14. Have you sought help about this situation from a union, an attorney, or any other source?

YES ____ NO ✓ If yes, from whom and when? Provide name of organization, name of person you spoke with and date of contact. Results, if any?

Signature Today's Date

If you have not heard from an EEOC office within 30 days of mailing this form, please call toll-free number shown on the letter accompanying this form. Please make a copy of this form for your records before mailing.

PRIVACY ACT STATEMENT: This form is covered by the Privacy Act of 1974: Public Law 93-579. Authority for requesting personal data and the uses thereof are:
1. FORM NUMBER/TITLE/DATE. EEOC Intake Questionnaire (10/2006).

2. AUTHORITY. 42 U.S.C. § 2000e-5(b), 29 U.S.C. § 211, 29 U.S.C. § 626, 42 U.S.C. 12117(a)

3. PRINCIPAL PURPOSE. The purpose of this questionnaire is to solicit information in an acceptable form consistent with statutory requirements to enable the Commission to act on matters within its jurisdiction. When this form constitutes the only timely written statement of allegations of employment discrimination, the Commission will, consistent with 29 CFR 1601.12(b) and 29 CFR 1626.8(b), consider it to be a sufficient charge of discrimination under the relevant statute(s).

4. ROUTINE USES. Information provided on this form will be used by Commission employees to determine the existence of facts relevant to a decision as to whether the Commission has jurisdiction over allegations of employment discrimination and to provide such charge filing counseling as is appropriate. Information provided on this form may be disclosed to other State, local and federal agencies as may be appropriate or necessary to carrying out the Commission's functions. Information may also be disclosed to respondents in connection with litigation.

5. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION. The providing of this information is voluntary but the failure to do so may hamper the Commission's investigation of a charge of discrimination. It is not mandatory that this form be used to provide the requested information.